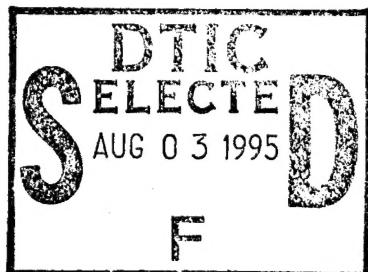


NAVAL POSTGRADUATE SCHOOL MONTEREY, CALIFORNIA



THESIS

**MILITARY HEALTH CARE SYSTEM:
COMPARING ORTHOPEDIC COSTS BETWEEN
A MILITARY
TREATMENT FACILITY AND CHAMPUS**

by

Geralyn A. Haradon

December, 1994

Principal Advisor:

William R. Gates

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REPORT DOCUMENTATION PAGE

Form Approved OMB No. 0704-0188

Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302, and to the Office of Management and Budget, Paperwork Reduction Project (0704-0188) Washington DC 20503.

1. AGENCY USE ONLY (<i>Leave blank</i>)		2. REPORT DATE December 1994		3. REPORT TYPE AND DATES COVERED Master's Thesis	
4. TITLE AND SUBTITLE Military Health Care System: Comparing Orthopedic Costs Between A Military Treatment Facility and CHAMPUS				5. FUNDING NUMBERS	
6. AUTHOR(S) Geralyn A. Haradon				8. PERFORMING ORGANIZATION REPORT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Naval Postgraduate School Monterey CA 93943-5000				9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)	
11. SUPPLEMENTARY NOTES The views expressed in this thesis are those of the author and do not reflect the official policy or position of the Department of Defense or the U.S. Government.				10. SPONSORING/MONITORING AGENCY REPORT NUMBER	
12a. DISTRIBUTION/AVAILABILITY STATEMENT Approved for public release; distribution is unlimited.				12b. DISTRIBUTION CODE	
<p>13. ABSTRACT (<i>maximum 200 words</i>)</p> <p>For more than three decades, two systems have provided healthcare for military beneficiaries: (1) the direct care system, whereby beneficiaries obtain health care services from military treatment facilities (MTFs), and (2) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), a health program in which beneficiaries receive care from civilian providers. The rising cost to the Department of Defense (DoD) of supplying quality medical care in a constrained financial environment, has prompted many suggestions for reforming the military health care system. The objective of this research is to compare costs between a military treatment facility and CHAMPUS and to determine whether a given MTF can provide inpatient care to its beneficiaries at lower cost than through CHAMPUS. By comparing MTF and CHAMPUS costs, a given MTF can identify those specialty areas in which to reduce costs either by increasing workload (CHAMPUS recapture) or increasing referrals to health care providers outside the MTF.</p>					
14. SUBJECT TERMS Direct VS Champus COSTS				15. NUMBER OF PAGES 76	
				16. PRICE CODE	
17. SECURITY CLASSIFICATION OF REPORT Unclassified	18. SECURITY CLASSIFICATION OF THIS PAGE Unclassified	19. SECURITY CLASSIFICATION OF ABSTRACT Unclassified	20. LIMITATION OF ABSTRACT UL		

NSN 7540-01-280-5500

Standard Form 298 (Rev. 2-89)
Prescribed by ANSI Std. Z39-18 298-102

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BETWEEN A MILITARY TREATMENT FACILITY AND CHAMPUS**

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Submitted in partial fulfillment
of the requirements for the degree of

MASTER OF SCIENCE IN MANAGEMENT

from the

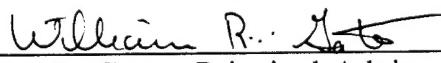
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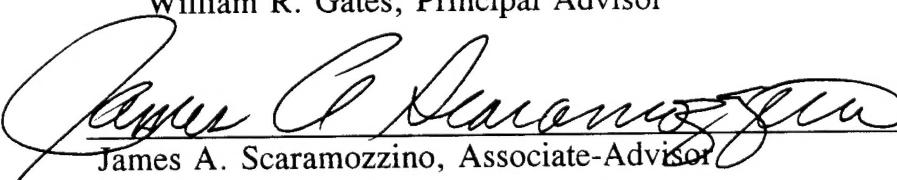
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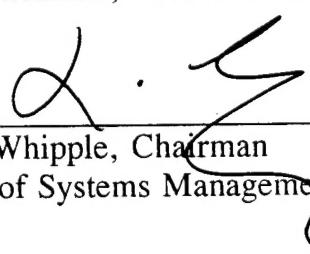
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ABSTRACT

For more than three decades, two systems have provided health care for military beneficiaries: (1) the direct care system, whereby beneficiaries obtain health care services from military treatment facilities (MTFs), and (2) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), a health program in which beneficiaries receive care from civilian providers. The rising cost to the Department of Defense (DoD) of supplying quality medical care in a constrained financial environment, has prompted many suggestions for reforming the military health care system. The objective of this research is to compare costs between a military treatment facility and CHAMPUS and to determine whether a given MTF can provide inpatient care to its beneficiaries at lower cost than through CHAMPUS. By comparing MTF and CHAMPUS costs, a given MTF can identify those specialty areas in which to reduce costs either by increasing workload (CHAMPUS recapture) or increasing referrals to health care providers outside the MTF.

TABLE OF CONTENTS

I.	INTRODUCTION	1
A.	BACKGROUND	1
B.	OBJECTIVES OF THE RESEARCH	1
C.	RESEARCH QUESTION	3
D.	SCOPE	3
E.	METHODOLOGY	4
II.	THE MILITARY HEALTH SERVICES SYSTEM	5
A.	OVERVIEW OF THE MILITARY HEALTH SERVICES SYSTEM	5
B.	THE DIRECT HEALTH CARE SYSTEM OF MHSS	7
C.	THE INDIRECT MHSS HEALTH CARE SYSTEM	10
D.	THE EVOLUTION OF MANAGED CARE	12
E.	TRICARE REGIONAL MANAGED CARE SYSTEM	14
	Capitation Budgeting Concept	15
	The "Triple Option" TRICARE Plan	16
	TRICARE Standard	16
	TRICARE Prime	16
	TRICARE Extra	17
	The Lead Agent Concept	17
	TRICARE Managed Care Support Contracts	18
III.	METHODOLOGY	19
A.	SOURCES OF DATA	19
B.	OVERVIEW OF MEPRS	19
C.	MEPRS DATA FOR INPATIENT ORTHOPEDIC CARE	21
D.	OVERVIEW OF THE HEALTH CARE SUMMARY REPORT	22
E.	CALCULATING COSTS FOR INPATIENT ORTHOPEDIC TREATMENT	22
IV.	DISCUSSION AND RECOMMENDATIONS	25
A.	SUMMARY	25
	Actual versus Estimated Cost Savings	26
B.	CONCLUSIONS	28
C.	RECOMMENDATIONS	30
D.	AREAS FOR FUTURE RESEARCH	31
APPENDIX A.	EXAMPLE OF PERFORMANCE DESCRIPTIONS	33
APPENDIX B.	STATISTICAL DATA SET (OCCUPIED BED DAY DATA)	35
APPENDIX C.	DIRECT EXPENSE SUMMARY	37
APPENDIX D.	STEPDOWN SCHEDULE	39
APPENDIX E.	FINAL PURIFICATION	47
APPENDIX F.	COMPUTATION SUMMARY	49
APPENDIX G.	HEALTH CARE SUMMARY	55
APPENDIX H.	SUMMARY OF COSTS/WORKLOAD	59
APPENDIX I.	INPATIENT SPECIALTY	61
APPENDIX J.	GLOSSARY	63
APPENDIX K.	MAY'S METHODOLOGY	65
LIST OF REFERENCES		67
INITIAL DISTRIBUTION		69

I. INTRODUCTION

A. BACKGROUND

For more than three decades, two systems have provided health care for U. S. military beneficiaries: (1) the direct care system, whereby beneficiaries obtain health care services from military treatment facilities (MTFs), and (2) the Civilian Health and Medical Program of the Uniformed Service (CHAMPUS), a health program in which beneficiaries receive care from civilian facilities. [Ref. 17:p. v]

The Department of Defense (DoD) now spends \$15 to \$17 billion a year on medical services. About \$5 billion of this spending covers the military treatment facilities (MTFs). DoD's desire to minimize the cost of providing medical care while maintaining quality and timeliness of service, has prompted many suggestions for reforming the military health care system.

CHAMPUS is the Civilian Health and Medical Program of the Uniformed Services, a Department of Defense program for reimbursing individuals and health care providers for services provided by the civilian sector to eligible beneficiaries and retirees. It pays most of the costs for treatment in civilian medical treatment facilities when space and resource constraints at military hospitals and clinics make direct care inaccessible. The family members of active-duty personnel, retirees and their dependents under 65, some former spouses of service members, and certain survivors are eligible for CHAMPUS. Families of reserve and National Guard members called to active duty are also eligible.

B. OBJECTIVES OF THE RESEARCH

For the past decade, the CHAMPUS budget has grown substantially for several reasons. First, the Department of Defense has significantly expanded in size, increasing the number of military personnel whose medical care is the

military's responsibility. Additionally, there is a greater percentage of service personnel entering the military with family members, compared to previous years. These additional family members, especially children, have a tremendous need for medical services. Consequently, the need for health care far exceeds the capacity of overburdened military providers. Second, there is a rise in total national health care expenditures. [Ref. 13:p. I-3,5] These costs have grown excessively when compared to inflation.

In Fiscal Year (FY) 1993, approximately 8.7 million people were eligible for DoD health care benefits, including 1.9 million active duty personnel, 2.7 million family members, and 4.1 million retired military personnel and their dependents and survivors. From Operations & Maintenance (O&M) funds, CHAMPUS expenditures in FY-93 approached \$3.5 billion, nearly as much as was spent on non-active duty beneficiaries in the "direct care" military treatment facility (MTF) system (\$3.9 billion). Over the last few years, a variety of modifications to the MTF and CHAMPUS systems have been implemented to reduce these costs. These include the CHAMPUS Reform Initiative (CRI) demonstrations, Base Realignment and Closure (BRAC) site managed care initiatives, Tidewater Virginia demonstration project (coordinated care), PRIMUS/NAVCARE Clinics, and most recently, the Managed Care Support Contract for California/Hawaii and Oregon/Washington.

The objective of this research is to compare direct care (MTF) and Standard CHAMPUS costs to determine whether a given MTF can provide inpatient care to its beneficiaries for a particular specialty service at a lower cost than through CHAMPUS. The analysis provides a method of calculating MTF specialty cost per admission that can be compared to the equivalent specialty cost reported by

CHAMPUS.

C. RESEARCH QUESTION

The primary question of the thesis is: Is it more cost effective to treat non active duty beneficiaries for inpatient orthopedic care in the direct care system (MTF) or be refer them to the indirect care system?

D. SCOPE

This thesis will concentrate on Naval Hospital, Oak Harbor (an MTF) and its localized catchment area in the vicinity of Oak Harbor, Washington.¹ The analysis and cost comparison will be limited to Orthopedics because this specialty can be very resource intensive. The analysis will focus on inpatient orthopedic costs covered by Standard CHAMPUS funds in 1993. This is the most recent year for which complete and relevant data exists. For consistency, 1993 orthopedic costs will also be used for the Naval Hospital, Oak Harbor.

This study analyzes data generated prior to FY-95. As of 01 October 1994, there was a policy change regarding MTF financing. MTFs are now financed on a capitated rate, derived by the demographics of the catchment area. Each MTF is allocated a pre-determined capitated rate per beneficiary. This will change the MTF commanders' incentives for cost control in the MTF. In the past, MTF commanding officers had no incentive to reduce CHAMPUS costs because they were not responsible for CHAMPUS expenditures. Now each MTF commanding officer receives a CHAMPUS dollar target towards which to manage. If actual costs exceed this target, the MTF's O,M & N funds ultimately can be reduced by the amount the CHAMPUS target is exceeded. MTF commanding

¹This catchment area includes all beneficiaries residing near Naval Hospital, Oak Harbor (within a 40 mile radius) who use CHAMPUS as their primary insurer for inpatient care.

officers are responsible for providing all medical care for their beneficiary population within this capitated budget, irregardless of the actual level of service. Previously, MTFs were funded based on workload. The philosophy was, the more workload generated the more dollars received.

E. METHODOLOGY

Normally, participating health care providers are paid by CHAMPUS at a Champus Maximum Allowable Charge (CMAC). This is a Current Procedural Terminology (CPT) code specific reimbursement methodology developed by the Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS). It is used to reimburse all fee-for-service professional services for the CHAMPUS beneficiary population. OCHAMPUS uses this pricing methodology to compensate providers for the technical component of outpatient services, such as laboratory and radiology.

This research uses data on cost per admission from the CHAMPUS Inpatient Care Summary report. The CHAMPUS Inpatient Care Summary report provides the combined cost of hospital and professional services for 27 hospital specialties. The analysis concentrates on the CHAMPUS cost for orthopedic cases.

The MTF average cost per admission for orthopedic patients is developed using data from the Medical Expense and Performance Reporting System (MEPRS). MEPRS tracks total costs (hospitalization and physician costs) and occupied bed days (OBDs) by functional work centers. MEPRS data on cost per OBD by work center can be used to calculate average cost per admission based on the number of days the typical patient remains in each MEPRS work center. The cost of each admission is calculated by summing the product of the number of days spent in each work center and the corresponding cost per OBD.

II. THE MILITARY HEALTH SERVICES SYSTEM

A. OVERVIEW OF THE MILITARY HEALTH SERVICES SYSTEM

Health care for military beneficiaries is provided through a dual system: The Navy, Army, and Air Force operate approximately 137 hospitals and numerous clinics in the U. S. and overseas. When military treatment facilities cannot provide care for all eligible beneficiaries, their health care needs may be augmented by CHAMPUS, a health insurance plan that reimburses for health care services provided by civilian practitioners to military dependents and beneficiaries under age 65. [Ref. 17:p. 1]

The Military Health Services System (MHSS) is undergoing major changes, driven by the momentum of national health care reform, affecting both the health care options available to our beneficiaries and some of the functions and organizational structures of the Military Services' medical departments. The Department of Defense (DoD) health care reform program, known as TRICARE, is designed to promote the effective execution of the military health care mission, ensure access to a quality health care benefit, control health care costs, and respond to changing military and national health care priorities.

As with the rest of the country, the Department of Defense is experiencing a significant evolution in its health services system. Driving much of the change for DoD is the rapid downsizing of the Army, Navy and Air Force's active duty and reserve forces. Ships, aircraft squadrons, divisions and bases are being mothballed and eliminated at a fast pace, while the military personnel strength shrinks in response to the smaller force. Active duty soldiers, sailors, and airmen numbered 2.2 million at the peak of Operation Desert Storm. They are now at 1.7 million, on their way to 1.4, or possibly 1.2 million by 1996. At the

same time, health care costs move upward.

A number of factors contribute to cost escalation. One is the nature of the military medical mission. The primary focus of the Defense Department is deterrence of aggression through combat readiness. This applies equally to the medical forces. They must be constantly prepared for casualties, perhaps massive in number and severity. That requires a significant investment in medical resources and personnel deployed with the active forces around the world, and at medical treatment facilities. Maintaining large medical forces is costly in both dollars and manpower.

There is another cost associated with medical readiness. Medical professionals must continue to hone their skills, just as pilots, soldiers and sailors. Skill readiness has been historically achieved through providing space available services to dependents of active duty military, and to retirees and their family members. The diversity of the medical care needs presented by these groups has offered sufficient volume and intensity to keep health professionals well practiced.

However, space available status has led non-active duty personnel and family members to expect entitlement for health care services at the MTF despite the lack of legal foundation. The CHAMPUS indemnity program was established in the 1960's to provide care for beneficiaries in civilian facilities when military hospitals are over-burdened or unable to meet the specific medical needs of beneficiaries. During conflicts, such as Operation Desert Storm, Congress has acted to ensure the continued availability of care for non-active duty beneficiaries. During Desert Storm, a number of Reserve physicians and other providers were recalled specifically to maintain the level of service for beneficiaries at military medical treatment facilities.

B. THE DIRECT HEALTH CARE SYSTEM OF MHSS

To understand military medicine, it is important to note that active-duty individuals have first priority in the MTFs. Preserving the fighting force is military medicine's fundamental mission. Members on active duty receive free medical care, including hospitalization, medicines, immunizations, regular physical examinations and dental care. Also, all military hospitals can treat any member of the seven uniformed services: Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service, and National Oceanic and Atmospheric Administration. Any active-duty member that can not get to a military facility for emergency care may be treated at civilian hospitals; the military will pay the bill through the Office of Medical Affairs.

Other beneficiaries are treated only if medical staff and resources are available after treating those in uniform. Family members of active-duty members, including family members of reservists on active duty, have second priority. Retirees and their family members have lowest priority. As with any hospital, however, the military's priority list is put aside during emergencies. No one in need of emergency care is turned away.

Access to the Department of Defense's medical resources for non active duty beneficiaries is controlled by Defense Eligibility and Enrollment Reporting System (DEERS). This is the military's computerized data base of individuals eligible for military medical benefits; active-duty personnel are automatically enrolled while qualifying family members must be enrolled.

Families of active-duty members and activated reserves are eligible for treatment at military treatment facilities as long as they are enrolled in DEERS. Those qualifying as family members include:

1. The spouse and unmarried children (under 21 years of age) of active-duty members;
2. Unmarried children over 21 who receive more than 50 percent of their financial support from a military parent (limited to children with physical or mental handicap);
3. Unmarried children not yet 23 years of age who are full time students at accredited colleges and who must depend on a military parent;
4. Parents or parents-in-law who live in a residence provided or maintained by their active-duty son or daughter (in-law) and who receive more than half their financial support from the service member; and
5. Unremarried widows and widowers of active duty members or retirees. [Ref. 12:p. 15-20]

Family members can receive several kinds of medical services at military treatment facilities including: treatment of medical and surgical conditions, physical examinations, prescription and non-prescription drugs, emergency dental care, and ambulance service when medically necessary.

As with all health care programs, care is generally divided into outpatient and inpatient. Inpatient treatment occurs when an individual is admitted to a hospital with the reasonable expectation that such individual will stay at least 24 hours. Outpatient treatment occurs in a physician's office or clinic, or during a house call.

As with active-duty family members, retirees and their families are not charged for outpatient treatment at military treatment facilities. Retired members are not charged for inpatient care while retired officers and warrant officers pay a nominal fee of \$4.65 a day for meals (for FY-1994). Spouses and dependents of retirees' are billed \$9.30 a day (for FY-1994). See Figure 1.

Beneficiary	Out Patient	In Patient
Active Duty	X \$0.00	X \$4.65/day
Active Duty Beneficiary	SPACE A \$0.00	SPACE A \$9.30/day
Retired (Enlisted)	SPACE A \$0.00	SPACE A \$0.00
Retiree (Enlisted) Beneficiary	SPACE A \$0.00	SPACE A \$9.30/day
Retired (Officer)	SPACE A \$0.00	SPACE A \$4.65/day
Retired (Officer) Beneficiary	SPACE A \$0.00	SPACE A \$9.30/day

**Figure 1. Military Treatment Facility
Health Care Services Eligibility and Cost**

Retirees are also eligible for medical care from the Department of Veterans Affairs (VA). Priority is determined as follows:

First priority (Category A) includes all veterans with service connected disabilities; veterans claiming exposure to Agent Orange while serving in Vietnam; and those veterans claiming exposure to ionizing radiation through occupation in Hiroshima or Nagasaki, Japan following detonation of the nuclear device or through testing of those or other such devices. Veterans, such as former prisoners of war are automatically included in Category A. Also included are veterans with an annual income of \$19,912 or less if they have no dependents, or \$23,896 with one dependent, plus \$1330 for each additional dependent. This group is considered mandatory.

Discretionary care is provided if space and resources are available, covers veterans with disabilities that are not service-connected and whose annual income is less than \$19,912 if they have no family members, or less than \$23,896 with one dependent, plus \$1,330 for each additional dependent. Veterans in this category must pay a deductible equal to what is paid under Medicare, \$696 in 1994.

They are also charged \$10 a day for inpatient care, \$5 a day for nursing home care, and \$36 for each outpatient visit. [Ref. 14: interview]

In an effort to alleviate overcrowding at hospitals, the services have opened a number of medical clinics. These clinics are manned by civilian health care providers and offer primary care to both active-duty personnel, retirees and family members. The Navy calls its clinics NavCare; the Army and Air Force call them PRIMUS. Eligible members and their families may enter any of these clinics, and receive service free of charge. Services include treatment for minor illnesses, routine physical exams, diagnostic services, X-rays, prescriptions and laboratory tests.

Members on active-duty are also entitled to receive dental care in military dental clinics. In order of priority, active-duty family members, including family members of recalled reservists, retirees, and retirees' family members may also receive emergency dental care at these facilities on a space available basis. Such care is free, except that family members must pay for prosthetic devices. These charges reflect the cost of the materials and not manpower costs.

The Department of Defense also offers active-duty family members in the U. S. and its territories dental treatment by participating civilian dentists through an insurance plan. The plan provides free diagnostic care, oral exams, and preventive care such as fluoride treatments. The plan pays 80 percent of other charges and the patient pays 20 percent. [Ref. 9:pp. 1-5]

C. THE INDIRECT MHSS HEALTH CARE SYSTEM

CHAMPUS was created by Congress when eligible beneficiaries were unable to access military treatment facilities. Its budget has been rising steadily for several years. In 1993, its total DoD budget was \$3,608,800 up from

\$3,372,600 in 1992. [Ref. 15:p. 1] In 1993, the total number of claims was 18,673,383 up from 17,910,083 in 1992. [Ref. 15:p. 1]

The Champus program offers a "triple option" system which provides standard, prime, and extra options. The standard option is basically an indemnity insurance that pays 80 percent of allowed charges while the beneficiary pays 20 percent after deductibles are met. The prime option is like a Health Maintenance Organization (HMO) where members enroll and pay minimal co-payments when treatment is sought from a specified list of providers. The extra option is like a Preferred Provider Organization (PPO) which is similar to the HMO but allows the beneficiary more choice in provider networks.

The following groups are eligible for CHAMPUS benefits: family members of active duty members; surviving spouses and unmarried children of service members and reservists who died while on active duty; spouses and unmarried children of reservists who are called to active duty for more than 30 days, and the survivors of reservists who died on active duty; members of the reserves between the age of 60 and 65 who are qualified to receive retired pay; surviving spouses and children of deceased retirees (spouses who remarry are ineligible unless married to eligible member); and children of active duty members or retirees up to age 21 if not married, and to 23 years of age if not married and enrolled full time in an accredited college or university.

As a rule, CHAMPUS coverage automatically ends when a participant turns 65. Most military retirees and their family members lose CHAMPUS eligibility when they become eligible for Social Security's Medicare program. However, retirees and their family members maintain their privilege for treatment in military treatment facilities on a space available basis.

D. THE EVOLUTION OF MANAGED CARE

As America entered the twentieth century, society transformed from a predominantly agricultural economy to a manufacturing economy. The manufacturing economy gave rise to big business over small, family-owned operations causing a shift in focus from individual operation to that of institutional domination. [Ref. 16:p. 5]

During the last fifty years, society in every developed country has become a society of institution. Every major task whether performance or health care, education or protection of the environment, the pursuit of new knowledge or defense, is today being entrusted to big organizations, designed for perpetuity and managed by their own management. [Ref. 3:p. 6]

Simultaneously, in the medical arena, a historical transition from generalist to specialist occurred. This transition set the seed for corporate management of medical care. Specialized medicine quickly began to unfold during World War II. With the surge of new technology, physicians started to specialize in certain areas of medicine. There was an increased emphasis on specialized medical training and facilities. Physicians released from military service were entering residency programs in various specialties. At the end of World War II, practicing specialists started to flood the market as 100,000 medical personnel were released from active duty during the post war downsizing. By 1966, almost 70% of all practicing physicians were specialists while 30% were generalists.

Specialists began to practice in groups instead of working on their own. The costs of providing medical care, advances in technology, scientific evolution, and other economic forces were the main catalyst for this shift. Physicians would purchase expensive equipment as a group rather than practice on their own and bear all the expense.

Managed care has evolved over the past 50 years with Kaiser Permanente being the pioneer in this method of delivery system. The Kaiser Permanente Medical Care Program originated in 1942. It is the largest most widely distributed and best known health maintenance organization (HMO) in this country. [Ref. 2:p. 4] An HMO is a delivery system established to provide high quality health care medical services at a competitive price. Competition is the key variable. In order to remain competitive and attract new members, HMO's must continue to reduce cost and encourage "wellness" for its members. Keeping patients healthy allows the HMO to contain cost and provide appropriate medical care. After Kaiser Permanente proved successful at providing care through this type of delivery system, other group practices evolved into popular marketable entities that mirror the Kaiser system.

Preferred Provider Organizations (PPO) evolved as another managed care option. PPOs are slightly different than an HMO. A PPO is "a contractual arrangement between professional and/or institutional health care providers and employers, insurance carriers or third party administrators to provide health care services to a defined population at established fees." [Ref. 2:p. 5] In other words, a PPO is a loosely integrated network of health care providers. All members have agreed to provide services for a predetermined maximum price. Patients are free to choose between all member health care providers. Thus, PPO's allow the patient more choice than an HMOs: They represent a competitive form of bureaucratic organization in medical care. [Ref. 2:p. 27]

By mid 1979, there were 217 HMO's operating across the nation with a total enrollment of 7.9 million people. This figure had doubled in size since 1970. Clearly, a primary reason that HMO's have been successful is that physicians

have been able to accept some financial risk - the financial risk associated with providing medical care and services to a group of subscribers for a predetermined total cost. Both profits and losses are shared by all the physicians.

The Department of Defense has also begun to pursue innovative approaches to reinvent their health care delivery system. There were various projects tested throughout the United States such as CHAMPUS Reform Initiative (CRI) in California and Hawaii, CAMS in Charleston, South Carolina, and TRICARE Demonstration Project in Virginia. Reinventing the delivery of health care is a major undertaking for any organization, especially the military. The TRICARE project has been adopted by the three military services. It has involved developing 12 geographical regions, each with a designated Lead Agent to coordinate all medical care for that specific region.

E. TRICARE REGIONAL MANAGED CARE SYSTEM

In 1993, DOD has added several new components to the MHSS to begin its transition to a managed care concept of operation:

1. DoD is transitioning to a "capitation-based" method for allocating health care funds to the military departments. Capitation budgeting is a recognized strategy for health care cost containment. Under this concept, each MTF commander is responsible for providing health care services to a defined population for an average fixed amount per beneficiary.
2. DoD developed the "Triple Option" managed care program structure for CHAMPUS eligible beneficiaries.
3. DoD established 12 Health Service Regions (HSRs) within the U. S., each lead by a medical center commander designated as a Lead Agent. (see Figure 2).

4. DoD implemented a fixed-price-at-risk TRICARE Support Contract.² The support contractor established a network of civilian providers to augment MTF care within each area. The contractor provides fiscal and administrative support to Lead Agents for care purchased through these networks. These fixed-price -at-risk contracts will be procured centrally by OCHAMPUS, with extensive participation by the Lead Agent and Services' staffs. The contractor is expected to assist Lead Agents and MTFs to improve access to quality health care while controlling health care cost.

Capitation Budgeting Concept

A capitation-based resource allocation system is increasingly advocated to consolidate resources, develop services, focus responsibility, and manage care appropriately. Basically, capitation budgeting can be defined as a prospective reimbursement process where the health care provider is paid a fixed price per person to provide a defined range of services over a specified time period. [Ref. 12:p. 6] Under this definition, capitation has three crucial elements: (1) care is prepaid with a predetermined, agreed-upon price, and price does not vary according to the value or intensity of services; (2) the payment is tied to a specific population of capitated patients, typically involving some type of an enrollment system; and (3) the provider bears full financial risk if expenditures exceed payments. The provider keeps part of the savings, if not all of the medical costs are within the capitated payment. Similarly, the provider is liable for any costs that exceed the capitated budget. Combined, these

²A fixed-price-at-risk contract protects the contractor from financial risk as its workload is increased or decreased by the MTF.

elements give the provider a strong incentive to manage care wisely. [Ref. 12:p. 7]

Capitation budgeting fundamentally governs the users' payment to the organization providing health care. [Ref. 12:p. 8] It is not required that doctors or other professional personnel be paid on a per capita basis under capitation budgeting. Providers could be paid by the program in a wide variety of ways, including salary and fee-for-service. Those who finance care are more concerned with controlling aggregate costs than with the particular mode of remuneration among providers. [Ref. 12:p 8]

The "Triple Option" TRICARE Plan

The foundation of the TRICARE Program is a "triple option" of health care delivery for CHAMPUS eligible beneficiaries. Beneficiaries may choose from the following options:

TRICARE Standard: Individuals in this program enjoy unrestricted provider choice and pay no enrollment fees, but pay annual deductibles, co-payments and cost shares. This program is the basic CHAMPUS standard indemnity fee-for-service plan.

TRICARE Prime: Individuals in this program enroll in an HMO like plan and obtain their care from a network of civilian and military providers/hospitals. Enrolles pay an annual enrollment fee but face lower CHAMPUS cost shares and co-payments for point-of-service charges. Enrolles have access to enhanced preventive care services under this plan. They also have a Primary Care Manager (PMC). This doctor is responsible for coordinating required patient referrals for care within the MTF or civilian provider network. The point-of-service option under TRICARE Prime, allows enrolles to "go outside the provider network" for care. However, they are required to pay significant cost shares and deductibles which could exceed Standard CHAMPUS costs.

Finally, participants are relieved of claim filing responsibilities.

TRICARE Extra: Individuals don't have to enroll in this program, but agree to obtain care from their choice of providers within the PRIME network. Beneficiaries don't file claims and pay lower cost shares than required for non-network providers under the Standard CHAMPUS option.

The Lead Agent Concept

As previously stated, DoD established 12 Health Service Regions (HSR) within the United States, each with a designated Lead Agent MTF/Commander. Lead Agents work cooperatively with all the services' regional MTF commanders and their staffs to develop, implement, and manage the regional health plan for their MHSS beneficiaries. This includes developing an integrated health care network within their HSR. Lead Agents are responsible for:

1. developing an annual regional health service plan
2. developing clinical support contingency plans
3. developing regional TRICARE Support Contract requirements
4. developing procedures for coordinating health care delivery between military and civilian health care providers
5. monitoring CHAMPUS budget targets
6. coordinating utilization management and quality assurance activities
7. establishing priorities for routing beneficiaries to the direct care system
8. developing regional policy for coordinating patient referrals and issuing non-availability statements (NAS) in accordance with DOD policy
9. coordinating the development of an annual regional capitalization, maintenance, repair and renovation plan for all MTFs within the HSR in concert with

regional MTFs

10. conducting ongoing evaluations and coordinating corrective actions relative to resource utilization, clinical services, and access as appropriate.

MTF Commanding Officers retain their Service designated Chain of command irrespective of their Lead Agent's Service affiliation. The Lead Agent has no command and control over the individual MTFs within their region. The Lead Agent's report to their service specific headquarters and the Assistant Secretary of Defense for Health Affairs. Each Service will retain existing authority to make decisions regarding direct care (MTF) operating funds, facility maintenance, and personnel actions. For the Lead Agent concept of managing CHAMPUS resources to be successful requires each service within the region to work together openly and cooperatively.

TRICARE Managed Care Support Contracts

The transition from an exclusive fee-for-service (Standard CHAMPUS) program to the TRICARE Triple Option as described is now underway and will be completed within the next three years. These fixed-price at-risk contracts will be procured centrally by OCHAMPUS, with extensive participation of the Lead Agent and the Services' staffs, and will assist Lead Agents and MTFs in improving access to quality health care and controlling health care costs.

III. METHODOLOGY

A. SOURCES OF DATA

The data used for this research comes from two organizations. Naval Hospital Oak Harbor, Oak Harbor, Washington furnished the Medical Expense and Performance Reporting System (MEPRS) and occupied bed day (OBD) data on inpatient orthopedic care for fiscal year 1993.

The Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) in Aurora, Colorado provided the Health Care Summary Report. The Health Care Summary Report shows CHAMPUS utilization and cost data for the Oak Harbor catchment area.

B. OVERVIEW OF MEPRS

MEPRS contains cost and workload performance information for military treatment facilities. MEPRS recognizes six general functional areas within an MTF: inpatient, outpatient, dental, ancillary services, support services, and special programs. Support services are laundry service, food service, housekeeping, and other non medical functions. Ancillary services include clinical laboratory, pathology, radiology, pharmacy, and other related activities that contribute to the proper diagnosis and treatment of admitted patients. Special programs consist of graduate medical education, public health services, and decedent affairs. Within the general functional areas, MEPRS further identifies separate work centers of the MTF in which different services are performed. It tracks workload and expenses by these work centers.

Average expenses from ancillary and support work centers are reallocated or reassigned to the work centers and other final operating accounts. This allocation is based on the percentage of the ancillary and support workload performed for the work centers. For example, the

performance factor for Blood Bank is a weighted procedure (see Appendix A for sample of performance factors). If 20% of Blood Bank laboratory procedures (i.e tests performed to prepare units of blood for patients) are requested by the Orthopedics physicians, then 20% of the cost of operating the Blood Bank are allocated to Orthopedics care (work center).

Expense information is entered in the MEPRS as a Direct Expense Schedule (DES). The DES identifies all expenses directly associated with a given work center including the ancillary and support work centers. Information is provided by the departments and is then rolled up by the MEPRS system. Workload information is gathered from numerous sources, including the Automated Quality of Care Evaluation Support System (AQCESS) and the Tri-service Medical Information System (TRIMIS). AQCESS provides OBDs by work center and TRIMIS provides ancillary workloads.

Workload statistics are calculated in MEPRS through stepdown assignment statistics (SAS) data sets. Each SAS data set includes a numerical identifier that is related with a specific workload measure and a list of the MEPRS work centers and corresponding workload for that work center.

The Expense Allocation System (EAS) is the automated system that processes the actual cost allocations from the intermediate operating accounts to the final accounts. EAS charges direct expenses of the ancillary and support work centers to the inpatient, outpatient, dental, or special programs work centers benefiting from the expenses.

During the final purification or post-stepdown, expenses from cost pools are allocated to final operating accounts in EAS. Cost pools are established when costs are shared by two or more final operating accounts.

The Final Purification Report identifies the expense

distribution from cost pools to final accounts. This report shows the dollar amounts calculated and allocated during purification.

The Computation Summary reveals the breakdown of total work center expense by direct expense, support costs, ancillary costs, expense from cost pools, and a final purified amount.

C. MEPRS DATA FOR INPATIENT ORTHOPEDIC CARE

Data provided by Naval Hospital, Oak Harbor, Washington covered only the inpatient services and work centers involving Orthopedic costs.³ Five reports were used for analyzing Orthopedic cases. These reports are included as Appendices B, C, D, E, and F. Appendix B (Occupied Bed Day Data) accounts for all the occupied bed days for the inpatient work centers. Appendix C (Direct Expense Summary) shows the total salary of clinicians working in those particular work centers. Appendix D (Stepdown Schedule) enumerates all the ancillary and support costs allocated to the affected work centers. Appendix E (Final Purification Report) shows the costs allocated to different work centers from the ward cost pools. Appendix F (Computation Summary Report) integrates all the different costs allocated to the work centers.

Naval Hospital Oak Harbor provided their complete MEPRS data for FY-93 (01 October 1992 to 30 September 1993). However, the data needs to be analyzed carefully because of MEPRS's inherent limitations. For example, data is collected by functional work center instead of by individual patient. When admitted patients in a given specialty are treated in two or more work centers, cost per admission must be calculated from data on cost per OBD by work center and

³To date, there are 6 identified inpatient specialties within the Naval Hospital Oak Harbor (see Appendix J-Inpatient Specialties).

treatment provided by the specialty. Second, since MEPRS is an allocative system, a work center's share of support and ancillary costs is determined by its relative share of weighted workload. If weights do not capture all differences in resource consumption for ancillary and support costs, then the allocated cost could be different from the true cost. As a result of these limitations, estimating the cost per admission in a given specialty using patient treatment protocols cannot truly reflect actual cost.

D. OVERVIEW OF THE HEALTH CARE SUMMARY REPORT

The Health Care Summary Report (HCSR) is produced by OCHAMPUS on a quarterly basis to show CHAMPUS utilization and health care expenditures at the individual MTF catchment area and regional level. The Health Care Summary Report provides CHAMPUS data broken out by hospital specialty.

The Health Care Summary Report provides data on various CHAMPUS statistics. The major breakouts of information on this report are:

Hospital Specialty - (Adverse Reactions, Allergy, Cardiology etc.)

Category of Beneficiary - (Family Members of Active Duty, Retirees, and Family Members of Retired/Deceased.)

Type of Care - (Hospital, Inpatient Professional, Outpatient Professional, and Outpatient Cost Shared as Inpatient)

E. CALCULATING COSTS FOR INPATIENT ORTHOPEDIC TREATMENT

For Orthopedic cases, the total expense is \$650,000 for Naval Hospital, Oak Harbor in fiscal year 1993⁴. This

⁴For the fiscal year 1993, 99.50% of patients admitted at Naval Hospital Oak Harbor for Orthopedics care were seen and treated at that work center. The remaining .50% were treated by two or more work centers. They were not included in the analysis because the effect is considered negligible in the final cost per admission.

includes all clinician and military salaries. Furthermore, 199 orthopedic patients were admitted in fiscal year 1993. Dividing \$650,000 by 199 yields a \$3266 average cost per orthopedic patients.⁵ The OBDs totaled 475. Dividing 475 OBDs by 199 patients yields a 2.387 average length of stay (ALOS) or occupied bed days (OBD). Furthermore, dividing the total expense of \$650,000 by occupied bed days yields \$1,368. These costs are summarized in Table 1. These costs can be compared to the CHAMPUS costs.

CHAMPUS Orthopedics cases for the fiscal year 1993 cost the government \$168,704 for 31 inpatient admissions (see Appendix G, Total All Categories of Beneficiaries section, NAS required). Dividing the total government cost by 31 total admissions yields a \$5,442.00 average government cost per admission. The total occupied bed days is 109. Dividing this by total admissions yields a 3.52 average length of stay or average OBD. Furthermore, dividing \$5,442.00 by the average OBD or length of stay yields a \$1546.00 average government cost per occupied bed day. These costs are also summarized in Table 1.

⁵May [Ref. 8] developed a methodology to estimate cost per admission where admissions involved several work centers. The cost per admission is determined from the treatment protocols and the cost per OBD for each work center. The cost is estimated as a weighted sum of the cost per OBD in each work center where the weights equal the number of days spent in each work center.

$$\text{Cost for each admission} = w_1 * C_1 + \dots + w_n * C_n \quad i=1 \text{ to } n$$

This methodology is not necessary in this case because orthopedic patients are only treated by one work center.

	Naval Hospital Oak Harbor	CHAMPUS	% Savings
Average Cost per Admission	\$3,266	\$5,442	40%
Average cost per Occupied Bed Day	\$1,368	\$1546	12%
Average Occupied Bed Day per Admission	2.39	3.52	32%

Table 1. Orthopedic Cost Comparison
between Direct Care and CHAMPUS for Naval Hospital,
Oak Harbor Catchment Area

IV. DISCUSSION AND RECOMMENDATIONS

A. SUMMARY

The data derived from the Cost Comparison Summary can be used to calculate the final costs and work-load for Orthopedic care incurred at Naval Hospital Oak Harbor and CHAMPUS for FY 1993. Referring to Appendix I, the average cost per admission at the MTF level is about \$3,266. This represents the average cost for inpatient care for one orthopedic specialty patient. It is derived by multiplying the average cost per occupied bed day, \$1,369, by the average length of stay, 2.39 days. The CHAMPUS cost for Orthopedic care per admission within the Oak Harbor catchment area is \$5,442. This number is derived from the CHAMPUS Health Care Summary Report.

This indicates there is a significant cost difference between the two programs. Assuming the cost per patient is unaffected by shifting the workload from CHAMPUS to the MTF, \$2,172 per patient represents a substantial savings.

Based on the data analyzed in this research, shifting CHAMPUS Orthopedics cases back to the Naval Hospital Oak Harbor could have significantly reduced the overall Orthopedic cost for the Oak Harbor catchment area for FY 1993. The potential savings represents almost a 40 percent reduction in the total CHAMPUS cost in all Orthopedic categories in the Oak Harbor area. The average MTF cost per OBD was 12 percent lower than the average CHAMPUS cost per OBD. The total savings exceeds the savings per OBD because MTF patients have a 32 percent lower average OBD per admission than CHAMPUS patients

It should be noted that the remaining five medical specialties within the Naval Hospital Oak Harbor were not compared and analyzed. Thus, the potential savings from these specialties and their impact on the overall CHAMPUS costs for the catchment area cannot be ascertained. The

other five medical specialties must be considered before drawing any conclusions about bringing orthopedic patients back into the MTF. If the MTF's total resources are limited, it should focus on those specialties providing the greatest cost savings. It would be inefficient for the MTF to use its limited resources to bring orthopedics back into the MTF if it could realize greater cost savings in other specialties.

Actual versus Estimated Cost Savings

There are extra costs associated with shifting any form of medical specialty. These costs may be significant. Examples of these costs are salaries of new doctors, additional ancillary costs, and other support costs. One way to forecast future cost when shifting patients is to use the established average cost per patient per occupied bed day. This represents the average cost incurred by the military hospital for doctors' salaries, ancillary services, and other support services for that work center.

When deciding to bring workload into the MTF one must consider the average cost versus the marginal cost. Using average costs to forecast the impact of shifting workloads implies that the rates of doctors, staff, support services, equipment, facilities, etc. per patient remain constant as the number of patients changes. If increasing the workload allows the MTF to use existing assets more efficiently, average cost will overstate the actual incremental cost of adding patients. If increasing the workload requires acquiring new assets (doctors, staff, equipment, etc.) average cost may underestimate the actual incremental cost of adding patients. Ideally, this analysis would compare the incremental cost of shifting workloads from CHAMPUS to the MTF. Unfortunately, incremental cost data is unavailable so average cost data is used as a proxy. It is unclear whether average cost is a good or bad proxy in this case.

Furthermore, there may be reasons for referring some CHAMPUS Orthopedic patients to civilian facilities that may help explain the cost differences between CHAMPUS and the MTF within the Oak Harbor catchment area. Some patients may require specialized equipment or medical staff unavailable at the MTF. Similarly, some severe cases may exceed the MTF's capabilities. To the extent that CHAMPUS patients reflect these factors, the cost savings would be overestimated here. Unfortunately, existing data does not reflect these factors. They must be determined on a case by case basis.

There are several other factors that make it difficult to estimate potential savings from shifting workload from CHAMPUS to the MTF. First, the potential savings that could be derived from shifting CHAMPUS workload depends upon the patients' private insurance coverage. For eligible family members who have private insurance, CHAMPUS is considered a secondary insurer. Therefore, it only pays charges not covered by the family members' insurance. This must be weighed against the insurance implications of recapturing the patient in the MTF. [Ref. 17:pp. 4-8]

Second, it is important to consider the potential effect on the quality of medical care and the population's overall satisfaction. Increasing the number of patients seen within a particular specialty may reduce access to that health care service. This may be observed in terms of both longer lines (waiting to make an appointment or follow-up) and the amount of time physicians spend with their patients. In addition, patients no longer have the option to see any specialist or doctor they choose (exceptions are emergency conditions). This may increase patient dissatisfaction and reduce actual or perceived quality.

Another issue to consider is the effect on the regional health care system outside the MTF. Effective, 01 March

1995, the Managed Care Support (MCS) contract will be implemented in the Washington/Oregon catchment areas. In this contract, the government has attempted to "fix" the contract cost. The objective is to reduce the contractor's risk due to changes in the actual workload. For cost elements where cost is fixed, the MCS contract includes a Bid Price and Bid Price Adjustment Formula. The Bid Price represents a fee-for-service rate. It is based on the projected CHAMPUS population and case mix. The Bid Price Adjustment formula adjusts the fee-for-service rate based on the actual CHAMPUS population case mix, CHAMPUS reimbursement policy and MTF utilization rate.

Normally, the contractor's revenue and profit would depend on its caseload and case mix. The contractor's profits could be at risk as its case load increased or decreased. To limit this risk, health care service prices will be adjusted to account for differences between the actual and projected levels of MTF utilization. Further, the contractor's expected level of inpatient costs may be influenced by shifts in inpatient casemix between CHAMPUS and the MTFs. Therefore, the bid prices for inpatient care will also be adjusted for changes in the CHAMPUS inpatient casemix, provided the smaller of the two changes in casemix reflects at least a two percent change relative to the data collection period.

As DoD "downsizes", the supply of military physicians within Naval Hospital Oak Harbor is limited, not only in Orthopedics, but in most clinical areas. This situation is not unique to Oak Harbor. It is common at other military treatment facilities as well. Some MTF services may have to be cut back, and some closed, due to the lack of resources.

B. CONCLUSIONS

The methodology described in this research provides a best estimate for centrally comparing Orthopedic costs

between a military treatment facility and CHAMPUS. The CHAMPUS cost per patient admission can be derived from the CHAMPUS Health Care Summary Report. The military treatment facility cost can be constructed using the cost per occupied bed day estimates from MEPRS. Since the data used in this analysis is based on average cost, Orthopedics appears to be lower at the MTF than through CHAMPUS.

The MEPRS data measures average cost. Average cost is the only data that is available. However, decisions to shift patients between the MTF and CHAMPUS should be based on incremental cost. Accuracy is also a question. It is a function of the individuals providing the data. The reliability of the data has been questioned. Another cost implication that must be examined is the acuity of the patients being referred. If more critical patients are being referred to civilian providers, it could explain the higher CHAMPUS cost. Finally, to maximize limited resources, the remaining five specialty areas must be examined. It could be more cost effective to bring other specialty care back into the MTF. Because of these considerations, it is difficult to recommend bringing orthopedic patients back into the MTF based on the cost data available.

Centralized data, as currently collected, can not be used to make or monitor cost effective decisions. Each command has local knowledge about individual facility capabilities that are not captured in statistical information and data. This data is critical for making appropriate decisions.

Ensuring correct decisions requires making these decisions at the local level. BUMED has started encouraging this by allowing commanding officers to make decisions if they can justify savings and manage the funding provided. If commanding officers are going to make prudent and

appropriate decisions, better information must be provided. In addition, MTF CO's must have appropriate incentives to manage direct dollars and CHAMPUS targets. The "triple option" and capitated budgets are a move in the right direction. When specific incentive systems are established, the system should be designed to encourage commanding officers to even go below target if quality is not compromised.

C. RECOMMENDATIONS

This research has analyzed and compared the costs of one medical specialty, Orthopedics, between a military treatment facility and its catchment area. Based on the average cost data analyzed, it appears that a significant savings could be realized by shifting patients back to the MTF. However, before attempting to shift major CHAMPUS workloads, a further study should be conducted on the other five specialties. This study would ascertain the full impact of possible changes in all specialty areas. It would help ensure appropriate changes are made.

When shifting CHAMPUS costs back to the MTF, commanding officers need to have the latitude to identify appropriate shifts, in concert with the Lead Agent. In order for the commanding officers to make the appropriate decision, an incentive system needs to be established that will encourage efficiency without future penalties (e.g. lowering the capitated rate or CHAMPUS target). To support the commanding officers in the decision making, appropriate data systems must be developed and accurate information has to flow freely. Data that is currently being used in the decision process is sometimes less than accurate and may measure the wrong inputs.

It should be noted that data utilized in this research was only based on beneficiaries using Standard CHAMPUS. This catchment area signed a TRICARE contract in October

1994 which will go into effect in March 1995. The contract will offer beneficiaries the "triple option". This is expected to provide a CHAMPUS cost savings in the future and could even further reduce specialty care cost. The "triple option's" cost impact should be monitored closely.

D. AREAS FOR FUTURE RESEARCH

1. Analyze the cost of the remaining five medical specialties at Naval Hospital Oak Harbor. Such a study should cover a two to three year span in order to determine if there is a continuous trend in MTF versus CHAMPUS costs.
2. Evaluate the Managed Care "Triple Option" program after the program has been implemented for at least one year. The study should ascertain if it is prudent to recapture patients or refer them to the contractor. The study should also evaluate DoD's financial impact of recapturing patients under the BID Price Adjustment Methodology.
3. Analyze the cost implications of recapturing patients that are not reflected in the current cost data. Some of these cost factors include:
 - patient severity
 - MTF resource availability
 - MTF capabilities
4. Examine Incentives at all levels (e.g., physicians, COs, Lead Agents, BUMED, patients, etc) to ensure that all stakeholders are encouraged to minimize health care cost while maintaining quality. Cost minimization requires each stakeholder to make the appropriate decision.
5. Examine procedures for setting capitated rates and CHAMPUS targets. Do these procedures encourage local decision makers to minimize the overall cost of medical care in their catchment area?

If not, how can they be modified.

6. Identify the data required to make appropriate decisions at each level. How should DoD's health care information system be modified to facilitate the decision making process.

APPENDIX A
EXAMPLE OF PERFORMANCE DESCRIPTIONS
NAVAL HOSPITAL OAK HARBOR, FY 93

<u>ACCT</u>	<u>DESCRIPTION</u>	<u>PERFORMANCE DESCRIPTION</u>
DAA	PHARMACY	WEIGHTED PROCEDURE
DBA	CLINICAL PATHOLOGY	WEIGHTED PROCEDURE
DBC	BLOOD BANK	WEIGHTED PROCEDURE
DCA	RADIOLOGY	WEIGHTED PROCEDURE
DDA	ELECTROCARDIOLOGY	PROCEDURE
DDD	PULMONARY FUNCTION	WEIGHTED PROCEDURE
DEA	CENTRAL STERILE SUPPLY	HOURS OF SERVICE
DFA	ANESTHESIOLOGY	MINUTES OF SERVICE
DFB	SURGICAL SUITE	MINUTES OF SERVICE
DHD	PHYSICAL THERAPY	VISIT
DGA	SAME DAY SURGERY	MINUTES OF SERVICE

APPENDIX B

STATISTICAL DATA SET (OCCUPIED BED DAY DATA)
NAVAL HOSPITAL, OAK HARBOR, FY 1993

UCA CODE	QTR 1	QTR 2	QTR 3	QTR 4
AAAA	41	23	2	8
ABAA	266	233	161	107
ACAA	65	52	47	27
ACBA	341	289	303	208
ADAA	64	77	83	38
ADBA	271	254	256	254
AEAA	95	124	94	49
AGAA	91	95	97	111
AGCA	51	34	44	40
AGDA	24	44	20	29
AGEA	3	0	0	0
AGHA	26	17	34	24

PREPARED: 94 OCT 04 1542 HRS DIRECT EXPENSE SUMMARY
 FACILITY NAME: NAVAL HOSPITAL OAK HARBOR
 FACILITY CODE: 066097
 DOD REGION: 11

QUARTER 4 : 01 JUL - 30 SEP FY 93
 PAGE 1- 2

ACCT	DES PAGE 1		DES PAGE 2		DES PAGE 3		DES PAGE 30		DES PAGE 31		DES PAGE 32		TOTAL
	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	
ADAA	0	0	0	0	0	0	4633	0	0	0	0	0	4633
ADBA	116565	0	0	0	0	0	25022	0	0	0	0	0	161587
AEAA	0	0	0	0	0	0	23234	0	0	0	0	0	23234
AGAA	0	0	0	0	0	0	10336	0	0	0	0	0	10336
AGBA	0	0	0	0	0	0	0	0	0	0	0	0	0
AGCA	0	0	0	0	0	0	11690	0	0	0	0	0	11690
AGDA	0	0	0	0	0	0	6916	0	0	0	0	0	6916
AGEA	0	0	0	0	0	0	0	0	0	0	0	0	0
AGHA	0	0	0	0	0	0	10863	0	0	0	0	0	10863
BAAA	18027	0	0	0	0	0	95250	0	0	0	0	0	113277
BALA	23364	0	0	0	0	0	0	0	0	0	0	0	23364
BBAA	38371	0	0	0	0	0	144505	0	0	0	0	0	182876
BCBA	0	0	0	0	0	0	0	0	0	0	0	0	0
BCCA	0	0	0	0	0	0	0	0	0	0	0	0	0
BCXO	2124843	0	0	0	0	0	274968	0	0	0	0	0	2124843
BDAA	1306	0	0	0	0	0	122277	0	0	0	0	0	276274
BEAA	28836	0	0	0	0	0	236811	0	0	0	0	0	151113
BFAA	59917	0	0	0	0	0	185867	0	0	0	0	0	296728
BFAX	168350	0	0	0	0	0	0	0	0	0	0	0	354217
BFEA	127311	0	0	0	0	0	72058	0	0	0	0	0	199369
BGAA	106252	0	0	0	0	0	634590	0	0	0	0	0	740842
BHAA	105	0	0	0	0	0	284902	0	0	0	0	0	285007
BHAE	3046	0	0	0	0	0	0	0	0	0	0	0	3046
BHCA	25274	0	0	0	0	0	222309	0	0	0	0	0	247583
BHGA	153004	0	0	0	0	0	138481	0	0	0	0	0	291485
BIAA	1958090	0	0	0	0	0	0	0	0	0	0	0	1958090
BJAA	13928	0	0	0	0	0	539426	0	0	0	0	0	553354
BLAA	17670	0	0	0	0	0	31794	0	0	0	0	0	49464
FAIA	0	0	0	0	0	0	0	0	0	0	0	0	525136
FALA	0	0	0	0	0	0	0	0	0	0	0	0	347924
FBBA	0	0	0	0	0	0	0	0	0	0	0	0	224486
FBCA	0	0	0	0	0	0	0	0	0	0	0	0	213555
FBIIA	0	0	0	0	0	0	0	0	0	0	0	0	165346
FCAA	0	0	0	0	0	0	0	0	0	0	0	0	94158
FCCA	0	0	0	0	0	0	0	0	0	0	0	0	94017
FCDA	0	0	0	0	0	0	0	0	0	0	0	0	0
FEAA	0	0	0	0	0	0	0	0	0	0	0	0	0
FIAA	0	0	0	0	0	0	0	0	0	0	0	0	0
FJAG	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	7666476	3331964	0	20381	5594424	0	6670683	0	22312	23306240	0	0	0

PREPARED: 94 OCT 04 1542 HRS
FACILITY NAME: NAVAL HOSPITAL OAK HARBOR
FACILITY CODE: 066097
REGION: 11

(APPENDIX D)

PCN NAA-Q10

QUARTER 4 : 01 JUL - 30 SEP FY 93 YEAR TO DATE
PAGE 1 - 1

MULTI-PREScription

PREPARED: 94 OCT 04 1542 HRS
 FACILITY NAME: NAVAL HOSPITAL OAK HARBOR
 FACILITY CODE: 066097
 DOD REGION: 11

PCN NAA-Q10

QUARTER 4 : 01 JUL - 30 SEP FY 93 YEAR TO DATE
 PAGE 1-2

ACCT	DESCRIPTION	DIRECT EXPENSE	EDBA	EDCA	EDDA	EDEA	EDGA	EDJA	EDVA
ADAA	PEDIATRICS	4633	0	0	13	1	1	1	1
ADBA	NURSERY	141587	150	0	68	1	1	1	1
AEAA	ORTHOPEDICS	23234	0	0	50	1	1	1	1
AGAA	FAMILY PRACTICE INTERNAL MEDICINE	10336	0	0	36	1	1	1	1
AGBA	FAMILY PRACTICE SURGERY	0	0	0	0	0	0	0	0
AGCA	FAMILY PRACTICE OBSTETRICS	11690	0	0	47	1	1	1	1
AGDA	FAMILY PRACTICE PEDIATRICS	6916	0	0	26	1	1	1	1
AGEA	FAMILY PRACTICE GYNECOLOGY	0	0	0	0	0	0	0	0
AGHA	FAMILY PRACTICE NURSERY	10863	0	0	27	1	1	1	1
BAAA	INTERNAL MEDICINE CLINIC	113277	58	0	399	1	1	1	1
BABA	NUTRITION CLINIC	23364	82	0	66	1	1	1	1
BBAA	GENERAL SURGERY CLINIC	182876	50	4	613	1	1	1	1
BCBA	GYNECOLOGY CLINIC	0	94	6	0	0	0	0	0
BCCA	OBSTETRICS CLINIC	0	94	6	3148	1	1	1	1
BCXO	OB GYN COST POOL	2124843	0	6	1129	1	1	1	1
BDAA	PEDIATRIC CLINIC	276274	76	6	555	1	1	1	1
BEAA	ORTHOPEDIC CLINIC	151113	49	3	1152	1	1	1	1
BEFA	PSYCHIATRY CLINIC	296728	102	7	1112	1	1	1	1
BFAX	CHAMPUS RECOUP	354217	0	0	422	1	1	1	1
BFEA	SOCIAL WORK SERVICES	199369	103	2	3275	1	1	1	1
BGAA	FAMILY PRACTICE CARE	740842	256	1	1619	1	1	1	1
BHAA	PRIMARY CARE CLINICS	285007	53	2	2977	1	1	1	1
BHAE	PRIMARY CARE CLINIC CONTRACT	3046	135	0	1596	1	1	1	1
BHCA	OPTOMETRY CLINIC	267583	178	0	852	1	1	1	1
BHGA	OCCUPATIONAL HEALTH CLINIC	291485	126	0	6560	1	1	1	1
BIAA	EMERGENCY MEDICAL CARE	1958090	225	15	2402	1	1	1	1
BJAA	FLIGHT MEDICINE CARE	553354	134	17	338	1	1	1	1
BLAA	PHYSICAL THERAPY	49464	0	19	3576	1	1	1	1
FAIA	PHYSIOLOGICAL TRAINING/SUPPORT PROG	525136	267	7	1290	1	1	1	1
FALA	TRAINING EXTERNALLY SPONSORED CHE	347924	0	0	1399	1	1	1	1
FBBA	PREVENTIVE MEDICINE	224486	21	2	435	1	1	1	1
FBCA	INDUSTRIAL HYGIENE	213555	23	2	477	1	1	1	1
FBIA	IMMUNIZATIONS	165346	22	0	0	0	0	0	0
FCAA	SUPPLEMENTAL CARE PURCHASED FROM CI	94158	0	0	469	1	1	1	1
FCCA	CHAMPUS BENEFICIARY SUPPORT	94017	8	0	1614	1	1	1	1
FCDA	SUPPORT TO OTHER MILITARY ACTIVITIES	212290	0	0	3620	1	1	1	1
FEAA	PATIENT TRANSPORTATION	397109	0	0	101	1	1	1	1
FIAA	READINESS TRAINING LOCAL	716	5	0	0	0	0	0	0
FJAG	MILITARY TRAVEL SOMOLIA	24638	0	0	0	0	0	0	0
		23306240							

PREPARED: 94 OCT 04 1542 HRS
 FACILITY NAME: NAVAL HOSPITAL OAK HARBOR
 FACILITY CODE: 066097
 DOD REGION: 11

PCN NAA-Q10

STEPDOWN SCHEDULE

QUARTER 4 : 01 JUL - 30 SEP FY 93 YEAR TO DATE

ACCT	EBBA	EBCA	EBDA	EBFA	EBGA	EBHA	EEAA	EFAA	EGAA	EHBA	EII
EDBA	0	0	0	0	0	0	0	0	0	0	0
EPCA	0	0	0	0	0	0	0	0	0	0	0
EDDA	0	0	0	0	0	0	0	0	0	0	0
EDEA	0	0	0	0	0	0	0	0	0	0	0
EDGA	0	0	0	0	0	0	0	0	0	0	0
EDJA	0	0	0	0	0	0	0	0	0	0	0
EBAA	0	0	0	0	0	0	0	0	0	0	0
EBBA	561752	43157	1387863	0	0	0	0	0	0	0	0
EBCA	EBDA	5112	13680	310416	0	0	0	0	0	0	0
EBFA	5163	13819	0	190475	0	0	0	0	0	0	0
EBGA	71	191	0	26	2658	0	0	0	0	0	0
EBHA	1550	4146	0	581	8	74360	0	0	0	0	0
EEAA	15425	41282	0	5780	80	0	530071	0	0	0	0
EFAA	11526	30846	0	4319	61	0	3255	521760	0	0	0
EGAA	5222	13974	0	1957	27	0	332	0	153067	0	0
EHBA	0	0	0	0	0	0	1444	0	0	0	0
EIBA	0	0	0	0	0	0	0	0	0	0	0
EJAA	24495	65554	0	0	0	0	0	5	0	0	0
EKAA	10966	29346	0	9178	128	0	303	5504	0	0	0
DEAA	1344	3598	0	4109	57	0	26	5505	0	0	0
DEBA	1717	4596	0	504	7	0	935	22580	11087	0	0
DAAA	25740	68883	0	644	9	0	25808	0	0	0	0
DBAA	18598	49773	0	9644	135	0	192283	16000	27770	0	0
DBCA	18993	5066	0	6970	97	0	36972	8436	7096	0	0
DCAA	13666	36574	0	709	10	0	1708	0	8436	2828	0
DCAE	5021	13436	0	5121	72	0	17608	14154	7928	5051	0
DDAA	57	152	0	1881	26	0	0	0	0	0	0
DDDA	102	272	0	21	0	0	0	0	0	0	0
DFAA	5511	14749	0	39	1	0	0	0	0	0	0
DFBA	18662	49943	0	2065	28	0	994	11290	4989	0	0
DFCA	2647	7086	0	6993	98	0	17309	11289	11143	0	0
AAA	36	96	0	992	14	0	0	0	0	0	0
AAXS	30714	82196	41	11509	13	0	0	0	0	0	0
ABAA	1016	2720	1345	381	161	0	2508	67894	6708	7577	0
ABEA	0	0	0	0	0	0	0	0	0	0	0
ACAA	585	1564	746	219	3	0	0	0	0	0	0
ACBA	579	1550	678	217	3	0	0	0	0	0	0
ACXO	58403	156298	68365	21884	306	0	4736	54423	5710	15154	0

50462 50000 201

PREPARED: 94 OCT 04 1542 HRS STEPDOWN SCHEDULE
FACILITY NAME: NAVAL HOSPITAL OAK HARBOR
FACILITY CODE: 066097
DOD REGION: 11

PCN NAA-010

QUARTER 4 : 01 JUL - 30 SEP FY 93 YEAR TO DATE
PAGE 2-2

ACCT	EBBA	EBCA	EBDA	EBFA	EBGA	EBHA	EEAA	EFAA	EGAA	EHBA
ADAA	75	201	88	29	0	0	0	0	0	0
ADBA	418	1118	489	156	2	0	2174	20162	8427	2473
AEAA	300	803	352	113	0	0	0	0	0	0
AGAA	222	595	260	83	1	0	0	0	0	0
AGBA	0	0	0	0	0	0	0	0	0	0
AGCA	288	771	337	108	1	0	0	0	0	0
AGDA	159	425	186	59	1	0	0	0	0	0
AGEA	0	0	0	0	0	0	0	0	0	0
AGHA	165	442	193	62	1	0	0	0	0	0
BAAA	2431	6506	2846	911	13	0	2289	6187	3659	0
BALA	402	1075	524	151	12	0	0	13606	0	0
BBAA	3737	10001	4375	1400	19	0	1133	1844	0	0
BCBA	0	0	0	0	0	0	0	6188	3493	0
BCCA	0	0	0	0	0	0	0	18058	3714	0
BCX0	19191	51358	22464	7191	101	0	0	18059	4435	0
BDAA	6878	18607	8051	2577	36	0	0	0	0	0
BEAA	3383	9053	3960	1268	17	0	0	2618	1663	0
BFAA	7022	18793	8220	2631	37	0	0	6188	3826	0
BFAX	6782	18152	7940	2542	36	0	0	20218	0	0
BFEA	2569	6874	3007	962	13	0	0	0	0	0
BGAA	19964	53427	23369	7481	104	0	0	20219	0	0
BHAA	9869	26413	11553	3698	52	0	0	1279	14713	0
BHAE	18147	48563	21241	6800	95	0	0	117	9376	0
BHCA	9729	26038	11390	3646	51	0	0	448	26742	0
BHGA	5194	13900	6079	1946	27	0	0	376	11278	0
BIAA	39990	107020	46812	14985	209	0	0	2099	24985	0
BJAA	14639	39178	17136	5485	77	0	0	81848	43379	0
BLAA	2063	5522	2416	774	11	0	0	1628	5673	0
FAIA	21796	58331	0	8167	114	0	0	1251	0	0
FALA	7866	21049	0	2947	41	0	0	345	0	0
FBBA	8526	22819	0	3195	44	0	0	0	0	0
FBCA	2652	7097	0	994	14	0	0	220	4274	0
FBIA	2911	7790	0	1091	15	0	0	363	0	0
FCAA	0	0	0	0	0	0	0	14279	1746	0
FFCCA	2857	7645	0	0	0	0	0	0	0	0
FCDA	9842	26338	0	3688	15	0	0	0	0	0
FEAA	22061	59042	0	8267	52	0	0	0	0	0
FIAA	33	89	0	115	0	0	0	0	0	0
FJAG	613	1638	0	12	0	0	0	0	0	0

PREPARED: 94 OCT 04 1542 HRS
 FACILITY NAME: NAVAL HOSPITAL OAK HARBOR
 FACILITY CODE: 066097
 DOD REGION: 11

PCN NAA-Q10

QUARTER 4 : 01 JUL - 30 SEP FY 93 YEAR TO DATE
 PAGE 3-1

ACCT	EIAA	EJAA	EKAA	DEAA	DEBA	DAAA	DBAA	DBCA	DCAA	DCAE
EDBA	0	0	0	0	0	0	0	0	0	0
EDCA	0	0	0	0	0	0	0	0	0	0
EDDA	0	0	0	0	0	0	0	0	0	0
EDEA	0	0	0	0	0	0	0	0	0	0
EDGA	0	0	0	0	0	0	0	0	0	0
EDJA	0	0	0	0	0	0	0	0	0	0
EBAA	0	0	0	0	0	0	0	0	0	0
EBBA	0	0	0	0	0	0	0	0	0	0
EBCA	0	0	0	0	0	0	0	0	0	0
EBDA	0	0	0	0	0	0	0	0	0	0
EBFA	0	0	0	0	0	0	0	0	0	0
EBGA	0	0	0	0	0	0	0	0	0	0
EBHA	0	0	0	0	0	0	0	0	0	0
EEAA	0	0	0	0	0	0	0	0	0	0
EFAA	0	0	0	0	0	0	0	0	0	0
EGAA	0	0	0	0	0	0	0	0	0	0
EHBA	0	0	0	0	0	0	0	0	0	0
EIBA	37	0	0	0	0	0	0	0	0	0
EIAA	0	0	0	0	0	0	0	0	0	0
EJAA	0	0	0	0	0	0	0	0	0	0
EKAA	0	0	0	0	0	0	0	0	0	0
DEAA	0	0	0	0	0	0	0	0	0	0
DEBA	0	0	0	0	0	0	0	0	0	0
DAAA	0	0	0	0	0	0	0	0	0	0
DBAA	0	0	0	0	0	0	0	0	0	0
DBCA	0	0	0	0	0	0	0	0	0	0
DCAA	0	0	0	0	0	0	0	0	0	0
DCAE	0	0	0	0	0	0	0	0	0	0
DDAA	0	0	0	0	0	0	0	0	0	0
DDDA	0	0	0	0	0	0	0	0	0	0
DFAA	0	0	0	0	0	0	0	0	0	0
DFBA	0	0	0	0	0	0	0	0	0	0
DFCA	0	0	0	0	0	0	0	0	0	0
AAAA	0	0	0	0	0	0	0	0	0	0
AAXS	0	0	0	0	0	0	0	0	0	0
ABAA	8	0	0	0	0	0	0	0	0	0
ABEA	0	0	0	0	0	0	0	0	0	0
ACAA	2	0	0	0	0	0	0	0	0	0
ACBA	13	202507	0	0	0	0	0	0	0	0
ACX0	0	0	0	0	0	0	0	0	0	0
			14683	52056	0	0	0	0	0	0

QUARTER 4 : 01 JUL - 30 SEP 93 YEAR TO DATE
PAGE 3-2

REARED: 94 OCT 04 NAME: NAVAL HOSPITAL OAK HARBOR
ACILITY CODE: 066097
ACILITY REGION: 11

PCN NAA-Q10

QUARTER 4 : 01 JUL - 30 SEP FY 93 YEAR TO DATE
 AGE 4-1

PREPARED: 94 OCT 04 1542 HRS
 FACILITY NAME: NAVAL HOSPITAL OAK HARBOR
 FACILITY CODE: 066097
 DOD REGION: 11

PCN NAA-Q10

QUARTER 4 : 01 JUL - 30 SEP FY 93 YEAR TO DATE

PAGE 4- 2

ACCT	DDDA	DFAA	DFBA	DFCA	TOTAL EXPENSE
ADAA	0	0	0	0	70663
ADBA	0	0	0	0	422277
AEAA	0	88152	246818	24153	468614
AGAA	0	0	0	0	91141
AGBA	0	0	0	0	2064
AGCA	0	0	0	0	47598
AGDA	0	0	0	0	30925
AGEA	0	0	0	0	564
AGHA	0	0	0	0	30010
BAAA	0	0	0	0	218325
BALA	0	0	0	0	42986
BBAA	0	0	0	0	401280
BCBA	0	0	0	0	229628
BCCA	0	0	0	0	379526
BCX0	0	0	0	0	2409463
BDAA	0	0	0	0	458498
BEAA	0	0	0	0	251104
BFAA	0	0	0	0	385206
BFAX	0	0	0	0	411637
BFEA	0	0	0	0	240685
BGAA	0	0	0	0	1733182
BHAA	0	0	0	0	658406
BHAE	0	0	0	0	780629
BHCA	0	0	0	0	371296
BHGA	0	0	0	0	446580
BJAA	0	0	0	0	3304428
JJAA	0	0	0	0	1122366
JLAA	0	0	0	0	94943
JAA	0	0	0	0	661418
ALA	0	0	0	0	396865
BBA	0	0	0	0	287853
FBCA	0	0	0	0	232662
FBIA	0	0	0	0	205844
FCAA	0	0	0	0	94158
FCCA	0	0	0	0	690655
FCDA	0	0	0	0	349149
FEAA	0	0	0	0	535755
JAG	0	0	0	0	28450
	5830	2144	468	0	23306240
				0	0
				0	0
				0	0

PREPARED: 94 OCT 04 1542 HRS FINAL PURIFICATION (APPENDIX E)
 FACILITY NAME: NAVAL HOSPITAL OAK HARBOR
 FACILITY CODE: 066097
 DOD REGION: 11

PCN NAA-Q12

QUARTER 4 : 01 JUL - 30 SEP FY 93 YEAR TO DATE
 PAGE 1-1

ACT	DESCRIPTION	EXP. AFT. STEPDOWN	AAXS	ACX0	BCX0	AMOUNT REASSND	PURIFIED EXPENSE
AAA INTERNAL MEDICINE	46004 51119	0	51119	0	0	51119	97123
AAXS WARD G COST POOL	1413663- 1413663- 827143 502680	0	0	0	0	1413663- 502680	0
ABA GENERAL SURGERY	0	0	0	0	0	0	0
ABEA OPHTHALMOLOGY	330248 122557	0	4973	0	0	127530	457778
ACAA GYNECOLOGY	495086 69470	0	1408648	0	0	1478118	1973204
ACBA OBSTETRICS	1606332- 1606332- ACXO WARD H COST POOL	0	1606332- 70663 96342	0	0	1606332- 96342	0
ADAA PEDIATRICS	422277 0	0	0	0	0	0	167005
ADBA NURSERY	468614 237249	0	0	0	0	0	422277
AEAA ORTHOPEDICS	91141 258221	0	0	0	0	0	705863
AGAA FAMILY PRACTICE INTERNAL MEDICINE	2064 0	0	0	0	0	0	349362
AGBA FAMILY PRACTICE SURGERY	47598 9175	0	192711	0	0	0	2064
AGCA FAMILY PRACTICE OBSTETRICS	30925 64883	0	0	0	0	0	249484
AGDA FAMILY PRACTICE PEDIATRICS	564 1967	0	0	0	0	0	95808
AGEA FAMILY PRACTICE GYNECOLOGY	30010 0	0	0	0	0	0	2531
AGHA FAMILY PRACTICE NURSERY	218325 0	0	0	0	0	0	30010
BAAA INTERNAL MEDICINE CLINIC	42986 0	0	0	0	0	0	218325
BALA NUTRITION CLINIC	401280 0	0	0	0	0	0	42986
BBAA GENERAL SURGERY CLINIC	229628 0	0	0	0	0	0	401280
BCBA GYNECOLOGY CLINIC	379526 0	0	0	0	0	0	1553354
BCCA OBSTETRICS CLINIC	2409463 0	0	0	0	0	0	1465263
BCX0 OB GYN COST POOL	0	0	0	0	0	0	0
BDDA PEDIATRIC CLINIC	458498 0	0	0	0	0	0	458498
BEAA ORTHOPEDIC CLINIC	251104 0	0	0	0	0	0	0
BFAA PSYCHIATRY CLINIC	385206 0	0	0	0	0	0	385206
BFAX CHAMPU RECROUP	411637 0	0	0	0	0	0	411637
BFEA SOCIAL WORK SERVICES	240685 0	0	0	0	0	0	240685
BGAA FAMILY PRACTICE CARE	1733182 0	0	0	0	0	0	1733182
BHAA PRIMARY CARE CLINICS	658406 0	0	0	0	0	0	658406
BHAE PRIMARY CARE CLINIC CONTRACT	780629 0	0	0	0	0	0	780629
BHCA OPTOMETRY CLINIC	371296 0	0	0	0	0	0	371296
BHGA OCCUPATIONAL HEALTH CLINIC	446580 0	0	0	0	0	0	446580
BIAA EMERGENCY MEDICAL CARE	3304428 0	0	0	0	0	0	3304428
BJAA FLIGHT MEDICINE CARE	1122366 0	0	0	0	0	0	1122366
BLAA PHYSICAL THERAPY	94943 0	0	0	0	0	0	94943
FAIA PHYSIOLOGICAL TRAINING/SUPPORT PROG	661418 0	0	0	0	0	0	661418
FALA TRAINING EXTERNALLY SPONSORED CHE	396865 0	0	0	0	0	0	396865
FBAA PREVENTIVE MEDICINE	287853 0	0	0	0	0	0	287853
FBCA INDUSTRIAL HYGIENE	232662 0	0	0	0	0	0	232662
FBIA IMMUNIZATIONS	205844 0	0	0	0	0	0	205844

PREPARED: 94 OCT 04 1542 HRS FINAL PURIFICATION
FACILITY NAME: NAVAL HOSPITAL OAK HARBOR
FACILITY CODE: 066097
DOD REGION: 11

PCN NAA-Q12

QUARTER 4 : 01 JUL - 30 SEP FY 93 YEAR TO DATE
PAGE 1- 2

ACCT DESCRIPTION	EXP. AFT. STEPDOWN	AAXS	ACX0	BCX0	AMOUNT REASSGNED	PURIFIED EXPENSE
FCAA SUPPLEMENTAL CARE PURCHASED FROM CI	94158	0	0	0	0	94158
FCCA CHAMPUIS BENEFICIARY SUPPORT	690665	0	0	0	0	690665
FCDA SUPPORT TO OTHER MILITARY ACTIVITIE	349149	0	0	0	0	349149
FEAA PATIENT TRANSPORTATION	535755	0	0	0	0	535755
FIAA READINESS TRAINING LOCAL	921	0	0	0	0	921
FJAG MILITARY TRAVEL SOMOLIA	28450	0	0	0	0	28450
	23306240	0	0	0	0	23306240

PREPARED: 94 OCT 04 1542 HRS
 FACILITY NAME: NAVAL HOSPITAL OAK HARBOR
 FACILITY CODE: 066097 DOD REGION: 11

COMPUTATION SUMMARY (APPENDIX F)

PCN NAA-Q13

QUARTER 4 : 01 JUL - 30 SEP FY 93

YEAR TO DATE

ACCT CODE	DIRECT EXPENSE	SUPPORT COSTS	ANCIL COSTS	AFTER STPDN	NET PURIF	PURIFIED EXPENSE
A	993066	1735737	1908350	5882332	0	5882332
AA	2238245	3258881	140720	1459667	1362544-	97123
AAA	1937	13740	30327	46004	51119	97123
*AAAAA	1937	312141	110393	46004	51119	97123
AAX	991129	312141	110393	1413663	1413663-	0
*AAXS	991129	158100	616699	1413663	1413663-	0
AB	52344	158100	616699	827143	502680	1329823
ABA	52344	158100	616699	827143	502680	1329823
*ABAAB	0	0	0	0	0	0
ABE	0	0	0	0	0	0
*ABEA	0	0	0	0	0	0
AC	983576	765288	682882	2431666	684-	2430982
ACA	0	39364	290884	330248	127530	457778
*ACAA	0	39364	290884	330248	127530	457778
ACB	38	213822	281226	495036	1478118	1973204
*ACBA	38	213822	281226	495086	1478118	1973204
ACX	983538	512102	110692	1606332	1606332-	0
*ACX0	983538	512102	110692	1606332	1606332-	0
AD	146220	268671	78049	492940	96342	589282
ADA	4633	48493	17537	70663	96342	167005
*ADAA	4633	48493	17537	70663	96342	167005
ADB	141587	220178	60512	422277	0	422277
*ADBA	141587	220178	60512	422277	0	422277
AE	23234	68522	376858	468614	237249	705863
AEA	23234	68522	376858	468614	237249	705863
*AEAA	23234	68522	376858	468614	237249	705863
AG	39805	149275	132222	202302	526957	729259
AGA	10336	73840	6965	91141	258221	349362
*AGAA	10336	73840	6965	91141	258221	349362
AGB	0	0	2064	2064	0	2064
*AGBA	0	0	2064	2064	0	2064
AGC	11690	33110	2798	47598	201886	249484
*AGCA	11690	33110	2798	47598	201886	249484
AGD	6916	22630	1379	30925	64883	95808
*AGDA	6916	22630	1379	30925	64883	95808
AGE	0	548	16	564	1967	2531
*AGEA	0	548	16	564	1967	2531
AGH	10863	19147	0	30010	0	30010
*AGHA	10863	19147	0	30010	0	30010
B	7850932	2354290	3734946	13940168	0	13940168
BA	136641	58931	65739	261311	0	261311
BAA	113277	39309	65739	218325	0	218325
*BAAA	113277	39309	65739	218325	0	218325
BAL	23364	19622	0	42986	0	42986
*BALA	23364	19622	0	42986	0	42986

PREPARED: 94 OCT 06 1542 HRS
 FACILITY NAME: NAVAL HOSPITAL OAK HARBOR
 FACILITY CODE: 066097 DOD REGION: 11

QUARTER 4 : 01 JUL - 30 SEP FY 93
 PAGE 02

COMPUTATION SUMMARY

ACCT CODE	DIRECT EXPENSE	SUPPORT COSTS	ANCIL COSTS	AFTER STPDN	NET PURIF	PURIFIED EXPENSE
BB	182876	49344	169060	401280	0	401280
BBA	182876	49344	169060	401280	0	401280
*BBAA	182876	49344	169060	401280	0	401280
BC	2124843	348805	544969	3018617	0	3018617
BCB	0	49431	180197	229628	1323726	1553354
*BCBBA	0	49431	180197	229628	1323726	1553354
BCC	0	45136	334390	379526	1085737	1465263
*BCCA	0	45136	334390	379526	1085737	1465263
BCX	2124843	254238	30382	2409463	2409463	0
*BCCX0	2124843	254238	30382	2409463	2409463	0
BD	276274	78281	103943	458498	0	458498
BDA	276274	78281	103943	458498	0	458498
*BDAA	276274	78281	103943	458498	0	458498
BE	151113	51309	48682	251104	0	251104
BEA	151113	51309	48682	251104	0	251104
*BEAA	151113	51309	48682	251104	0	251104
BF	850314	179538	7676	1037528	1037528	1037528
BFA	650945	138222	7676	796843	796843	796843
*BFAA	296728	80802	7676	385206	385206	385206
*BFAX	354217	57420	0	411637	411637	411637
BFE	199369	41316	0	240685	240685	240685
*BFEA	199369	41316	0	240685	240685	240685
BG	740842	249133	743207	1733182	1733182	1733182
BGA	740842	249133	743207	1733182	1733182	1733182
*BGAA	740842	249133	743207	1733182	1733182	1733182
BH	827121	596405	833385	2256911	2256911	2256911
BHA	288053	390655	760327	1439035	1439035	1439035
*BHAA	285007	123606	249793	658406	658406	658406
*BHAE	30466	267069	510534	780629	780629	780629
BHC	247583	118561	5152	371296	371296	371296
*BHCA	247583	118561	5152	371296	371296	371296
BHG	291485	87189	67906	446580	446580	446580
*BHGA	291485	87189	67906	446580	446580	446580
BI	1958090	534824	811514	3304428	3304428	3304428
BIA	1958090	534824	811514	3304428	3304428	3304428
*BIAA	1958090	534824	811514	3304428	3304428	3304428
BJ	553354	163248	405764	1122366	1122366	1122366
BJA	553354	163248	405764	1122366	1122366	1122366
*BJAA	553354	163248	405764	1122366	1122366	1122366
BL	494664	44472	1007	94943	94943	94943
BLA	494664	44472	1007	94943	94943	94943
*BLAA	494664	44472	1007	94943	94943	94943
D	5252948	1054193	260408	6567549	6567549	6567549
DA	2246533	371396	863	2618792	2618792	2618792
DAA	2246533	371396	863	2618792	2618792	2618792
*DAAA	2246533	371396	863	2618792	2618792	2618792

PREPARED: 94 OCT 04 1542 HRS
FACILITY NAME: NAVAL HOSPITAL OAK HARBOR
FACILITY CODE: 066097 DOD REGION: 11

COMPUTATION SUMMARY

PCN NAA-Q13

QUARTER 4 : 01 JUL - 30 SEP FY 93 YEAR TO DATE
PAGE 03

ACCT CODE	DIRECT EXPENSE	SUPPORT COSTS	ANCIL COSTS	AFTER STPDN	PURIFIED EXPENSE
DB	925190	191541	11634	1128365	0
DBA	890801	168395	6772	1065968	0
*DBAA	890801	168395	6772	1065968	0
DBC	343889	23146	4862	62397	0
*DBCA	343889	23146	4862	62397	0
DC	739125	161203	4479	904807	0
DCA	739125	161203	4479	904807	0
*DCAA	739125	129963	2361	871449	0
*DCAE	0	31240	2118	33358	0
DD	4920	12347	0	17267	0
DDA	1028	361	0	1389	0
*DDAA	1028	361	0	1389	0
DDD	3892	11986	0	15878	0
*DDDA	3892	11986	0	15878	0
DE	347003	79602	0	926605	0
DEA	71197	43089	0	114286	0
*DEAA	71197	43089	0	114286	0
DEB	275806	36513	0	243432	0
*DEBA	275806	36513	0	312319	0
DF	990177	238104	0	1471713	0
DFA	321750	51625	0	427631	0
*DFAA	321750	51625	0	54256	0
DFB	582574	156046	0	149722	0
*DFBA	582574	156046	0	888342	0
DFC	85853	30433	0	149722	0
*DFCA	85853	30433	0	888342	0
E	5664740	808539	0	39454	0
EB	3305159	370225	0	155740	0
EBA	1123886	23974	0	0	0
*EBAA	1123886	23974	0	0	0
EBB	536228	25524	0	0	0
*EBBA	536228	25524	0	0	0
EBC	1157147	230716	0	0	0
*EBCA	1157147	230716	0	0	0
EBD	265610	44806	0	0	0
*EBDA	265610	44806	0	0	0
EBF	155353	35122	0	0	0
*EBFA	155353	35122	0	0	0
EBG	2216	442	0	0	0
*EBGA	2216	442	0	0	0
EBH	64719	9641	0	0	0
*EBHA	64719	9641	0	0	0
ED	238876	0	0	0	0
EDB	105980	0	0	0	0
*EDBA	105980	0	0	0	0
EDC	7746	0	0	0	0

PREPARED: 94 OCT 04 1542 HRS COMPUTATION SUMMARY
FACILITY NAME: NAVAL HOSPITAL OAK HARBOR
FACILITY CODE: 066097 DOD REGION: 11

QUARTER 4 : 01 JUL - 30 SEP FY 93
PAGE 04

ACCT CODE	DIRECT EXPENSE	SUPPORT COSTS	ANCIL COSTS	AFTER STPDN	NET PURIF	PURIFIED EXPENSE
*EDCA	7746	0	0	0	0	0
EDD	236	0	0	0	0	0
*EDDA	236	0	0	0	0	0
EDE	7197	0	0	0	0	0
*EDEA	7197	0	0	0	0	0
EDG	18867	0	0	0	0	0
*EDGA	18867	0	0	0	0	0
EDJ	98850	0	0	0	0	0
*EDJA	98850	0	0	0	0	0
EE	433513	96558	0	0	0	0
EEA	433513	96558	0	0	0	0
*EEAA	433513	96558	0	0	0	0
EF	446543	75217	0	0	0	0
EFA	446543	75217	0	0	0	0
*EFAA	446543	75217	0	0	0	0
EG	120136	32931	0	0	0	0
EGA	120136	32931	0	0	0	0
*EGAA	120136	32931	0	0	0	0
EH	48990	1472	0	0	0	0
EHB	48990	1472	0	0	0	0
*EHBA	48990	1472	0	0	0	0
EI	20107	5	0	0	0	0
EIA	32	5	0	0	0	0
*EIAA	32	5	0	0	0	0
EIB	20075	0	0	0	0	0
*EIBA	20075	0	0	0	0	0
EJ	661001	158256	0	0	0	0
EJA	661001	158256	0	0	0	0
*EJAA	661001	158256	0	0	0	0
EK	390415	73875	0	0	0	0
EKA	390415	73875	0	0	0	0
*EKAA	390415	73875	0	0	0	0
F	229375	520520	663845	3483740	3483740	3483740
FA	873060	185223	0	1058283	1058283	1058283
FAI	525136	136282	0	661418	661418	661418
*FAIA	525136	136282	0	661418	661418	661418
FAL	347924	48941	0	396865	396865	396865
*FALA	347924	48941	0	396865	396865	396865
FB	603387	113610	9362	726359	726359	726359
FBB	224486	159622	3745	287853	287853	287853
*FBBA	224486	159622	3745	287853	287853	287853
FBC	213555	19107	0	232662	232662	232662
*FBCA	213555	19107	0	232662	232662	232662
FBI	165346	34881	5617	205844	205844	205844
*FBIA	165346	34881	5617	205844	205844	205844
FC	400465	79024	654483	1133972	1133972	1133972

PREPARED: 94 OCT 04 1542 HRS
 FACILITY NAME: NAVAL HOSPITAL OAK HARBOR
 FACILITY CODE: 066097 DOD REGION: 11

COMPUTATION SUMMARY

QUARTER 4 : 01 JUL - 30 SEP FY 93 YEAR TO DATE
 PAGE 05

ACCT CODE	DIRECT EXPENSE	SUPPORT COSTS	ANCIL COSTS	AFTER STPDN	NET PURIF	PURIFIED EXPENSE
FCA	94158	0	0	94158	0	94158
*FCAA	94158	0	0	94158	0	94158
FCC	94017	17785	578863	690665	0	690665
*FCCA	94017	17785	578863	690665	0	690665
FCD	212290	61239	75620	349149	0	349149
*FCDA	212290	61239	75620	349149	0	349149
FE	397109	138646	0	535755	0	535755
FEA	397109	138646	0	535755	0	535755
*FEAA	397109	138646	0	535755	0	535755
FI	716	205	0	921	921	921
FIA	716	205	0	921	921	921
*FIAA	716	205	0	921	921	921
FJ	24638	3812	0	28450	28450	28450
FJA	24638	3812	0	28450	28450	28450
*FJAG	24638	3812	0	28450	0	28450
*TOTAL	23306240	*****	*****	23306240		

APPENDIX H

SUMMARY OF COSTS/WORKLOAD

	Total Exp	OBD's	Cost Per OBD	Total Admiss.	Cost Per Admiss.	ALOS
MEPRS	650000	475	1368	199	3270	2.38
CHAMPUS	168704	109	1546	31	5442	3.52

APPENDIX I

INPATIENT SPECIALTY
NAVAL HOSPITAL OAK HARBOR, FY 1993

UCA CODE	DESCRIPTION
AAAA	INTERNAL MEDICINE
ABAA	GENERAL SURGERY
ACAA	GYNECOLOGY
ACBA	OBSTETRICS
ADAA	PEDIATRICS
ADBA	NURSERY
AEAA	ORTHOPEDICS
AGAA	FAMILY PRACTICE INTERNAL MEDICINE
AGCA	FAMILY PRACTICE OBSTERTICS
AGDA	FAMILY PRACTICE PEDIATRICS
AGEA	FAMILY PRACTICE GYNECOLOGY
AGHA	FAMILY PRACTICE NURSERY

APPENDIX J (GLOSSARY)

1. MTF - Military Treatment Facility
(same as Military Hospital)
2. DOD - Department of Defense
3. ALOS - average Length of Stay
4. FY - Fiscal Year
5. OBD - Occupied Bed Day
6. NAS - Non Availability Statement
7. CHAMPUS - Civilian Health and Medical Program of the
Uniformed Services
8. DEERS - Defense Eligibility and Enrollment Reporting
System
9. MEPRS - Medical Expense and Performance Reporting System

APPENDIX K (MAY'S METHODOLOGY)

Cost per admission = $w_i * C_i + \dots w_n * C_n$ $i = 1$ to n ,
where

w_i = number of OBD spent in work center i

C_i = cost per OBD in work center i

n = number of work centers.

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